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REGIONAL STRATEGY FOR HEALTH SECURITY AND EMERGENCIES 2016–2020

Report of the Secretariat

EXECUTIVE SUMMARY

1. The World Health Organization, African Region, is challenged by recurrent outbreaks and other health emergencies. These emergencies, most of which are preventable by addressing their underlying determinants, result in unacceptably high morbidity, mortality, disability and socioeconomic disruptions. They also threaten national, regional and global health security.

2. Presently, there is no global or integrated regional strategy that comprehensively addresses all public health emergencies. However, frameworks and guidelines have been developed to guide Member States. These include the legally-binding International Health Regulations (2005); the regional strategies on integrated disease surveillance and response and disaster risk management.

3. Despite the availability of these frameworks, guidelines and strategies, tackling health emergencies remains a huge challenge. This is largely due to fragmented implementation, limited intersectoral collaboration, inadequate resources, weak health systems, and inadequate IHR core capacities.

4. Learning from the recent Ebola response, WHO is undertaking major reforms to make it fit for purpose to address global health security. A new programme has been created across all the three levels of the Organization to address emergencies.

5. In view of the above, a regional strategy is required to guide Member States. It emphasizes the use of the **"***all-hazards approach***",** defined as "an integrated hazard management strategy that incorporates planning for and consideration of all potential natural and technological hazards". The strategy will contribute to the achievement of Sustainable Development Goal 3 which focuses on ensuring good health and well-being.

6. The Regional Committee is invited to review and adopt this strategy.

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INTRODUCTION

1. Member States frequently experience recurrent disease outbreaks and other public health emergencies. These result in high morbidity, mortality, disability and socioeconomic disruptions.[1] They also threaten national, regional and global health security. Although health security is the sovereign responsibility of Member States, the means to fulfil that responsibility are global.

2. The International Health Regulations - IHR (2005) constitute the essential vehicle for addressing global health security.[2] They aim at protecting global health security while avoiding unnecessary interference with international traffic and trade. The IHR capacity requirements are defined in *Article 5*. They include the capacity to detect, assess, notify and report events; capacity requirements for surveillance and response; and those for designated airports, ports and ground crossings.[3]

3. In the African Region, IHR is implemented in the context of integrated disease surveillance and response (IDSR). In addition, Member States have adopted the Regional Strategy for Disaster Risk Management (DRM). However, health system weaknesses in most Member States hinder emergency response. For instance, delays in the response to Ebola, meningitis and yellow fever outbreaks highlighted gaps in IHR implementation.[1,5] Member States have lagged behind in establishing the IHR core capacities.[4]

4. To strengthen the Region's capacities to prevent, detect and respond to public health emergencies, an all-hazard strategy that incorporates planning for all potential natural and technological hazards is required. In addition, the new WHO emergency programme which holistically addresses public health emergencies, offers an opportunity for improved support in line with the proposed holistic approach. This strategy provides a common framework to be implemented by all Member States within the broader realm of building resilient health systems. It will contribute to the attainment of Sustainable Development Goal 3.[5]

SITUATION ANALYSIS AND JUSTIFICATION

Situation analysis

5. Member States report over 100 public health emergencies annually. Of these, infectious diseases account for 80%, disasters for 18%, chemical poisoning and acute severe malnutrition account for 2%. Among the infectious diseases, cholera, measles, and meningitis are the most recurring. Others include the Ebola and Marburg viral diseases, chikungunya, typhoid, hepatitis, dengue, Rift Valley fever, yellow fever, plague, measles, monkey-pox and recently the Zika virus disease.[1] Most of the infectious diseases originate from animals because the health of humans,

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1 World Health Organization (2016). Mapping the Risk and Distribution of Epidemics in the WHO African Region: A technical report, Brazzaville, World Health Organization, Regional Office for Africa 2016.

2 World Health Organization (2015). Report of the Ebola Interim Assessment Panel - July 2015, accessed on 17 April 2016 at: http://www.who.int/csr/resources/publications/ebola/ebola-panel-report/en/

3 World Health Organization (2005). The IHR (2005). Second Edition, accessed on 17 April 2016 at: http://www.who.int/ihr/publications/9789241596664/en/

4 World Health Organization (2015). Implementation of the International Health Regulations (2005): Responding to public health Emergencies. Report by the Director General to the WHA, A68/22, accessed on 17 April 2016 at: http://apps.who.int/gb/ebwha/pdf_files/WHA68/A68_22-en.pdf

5 United Nations Sustainable Development Goal 3: Ensure healthy lives and promote well-being for all at all ages. http://www.un.org/sustainabledevelopment/health/: accessed on 21 June 2016.

animals and ecosystems are interconnected. Some emergencies are exacerbated by climate change and other environmental factors. Insufficient water and sanitation contribute significantly as a cause of major emergencies.

6. The entire Region is at risk of health emergencies.[1] Emerging and re-emerging pathogens are of particular concern. Ebola and Marburg, which were previously known to be rare, have caused major outbreaks. Recently, west Africa experienced an unprecedented Ebola outbreak with over 28 637 cases including 11 318 deaths, exceeding all past outbreaks combined. Between 1976 and 2012, 2420 cases and 1590 deaths were documented.[6]

7. Antimicrobial resistance constitutes another health security risk. It threatens the effective prevention and treatment of an ever-increasing range of infections caused by bacteria, parasites, viruses and fungi. It is an increasingly serious threat to global public health that requires action across all government sectors and society. Antimicrobial resistance is present in all parts of the world and new resistance mechanisms keep emerging and subsequently spreading globally.

8. Over the last four decades, the Region has experienced more than 1000 disasters. They are a major threat to development, putting economic gains at risk.[7] Rapid population growth, unplanned urbanization and the effects of climate change continue to impact negatively on the Region. For example, El Nino has devastated livelihoods and caused food insecurity and disease outbreaks in eastern and southern Africa.[8]

9. Each year, approximately 760 000 children under the age of five die from diarrhoeal diseases, leading causes of which are poor sanitation and unsafe drinking water.[9] Even when diarrhoeal episodes are not fatal, chronic diarrhoea in early childhood can contribute to malnutrition, with potential long-term consequences for child development. Further, unsafe food can transmit disease from person to person as well as serve as a growth medium for bacteria that can cause food poisoning.

10. Health emergencies also cause remarkable socioeconomic disruptions, leading to loss of productivity. For example, the Ebola epidemic reversed gains in economic growth in the most affected countries in west Africa. The loss in gross domestic product was approximately US$ 219 million in Sierra Leone, US$ 188 million in Liberia and US$ 184 million in Guinea.[10]

11. The IHR (2005), IDSR and disaster risk management strategy among others, have been developed and are being implemented. The African Public Health Emergency Fund (APHEF) which was created to provide seed funds for emergency response, is currently underfunded and its mechanisms are being revised to facilitate contributions. Moreover, weak and fragile health systems in most Member States and low levels of APHEF contributions have continued to hamper emergency response.

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6 World Health Organization (2013-2016). Ebola Situation Reports, 2013-2016, accessed on 17 April 2016 at: http://apps.who.int/ebola/ebola-situation-reports.

7 The World Bank (2013). Disaster Management in Africa, accessed on 17 April 2016 at: http://web.worldbank.org/wbsite/external/countries/africaext/

8 United Nations, Office for the Coordination of Humanitarian Affairs (2016). El Nino in East Africa. Accessed on 1 April 2016 at: http://www.unocha.org/el-nino-east-africa

9 World Health Organization. (2013). Factsheet: Diarrhoeal disease: http://www.who.int/mediacentre/factsheets/fs330/en, accessed on 21 June 2016.

10 United Nations Economic Commission for Africa (2015). Socio Economic Impacts of Ebola on Africa, accessed on 17 April, 2016 at: http://www.uneca.org/sites/default/files/PublicationFiles/eca_ebola_report_final_eng_0.pdf

Justification

12. Addressing health emergencies remains challenging due to inadequate preparedness and response capacities. Gaps in policy and legal frameworks have negatively affected the achievement of the IHR core capacities. Furthermore, insufficient resources (financial, human and logistical); fragmented services; limited community engagement; weak health systems; inadequate inter-country collaborations and limited partnerships present major challenges.

13. Recent developments offer opportunities to accelerate IHR implementation and improved coordination of processes and interventions aligned to available resources for better outcomes in the Region. These include the Global Health Security Agenda; the establishment of the Africa Centre for Disease Control and Prevention (Africa CDC), and stronger partnerships with the African Union Commission, regional economic communities and other stakeholders.

14. A strategy that holistically addresses health security and emergencies is required for the African Region. Moreover, the WHO Constitution and several World Health Assembly resolutions mandate the Organization to provide technical and strategic guidance in health emergencies.[11,12]

15. Learning from the recent Ebola response,-WHO has undertaken major reforms to make it fit for purpose to address global health security. A single platform has been created across all the three levels of the Organization to holistically address disease outbreaks and other health emergencies. A regional strategy that is aligned with these reforms is needed.

THE REGIONAL STRATEGY

Aim, Objectives and Targets

16. The aim of this strategy is to contribute to the reduction of morbidity, mortality, disability and socioeconomic disruptions due to outbreaks and other health emergencies in the WHO African Region.

17. **The objectives are:**

(a) To strengthen and sustain the capacity of all Member States to prepare for and prevent health emergencies.

(b) To strengthen and sustain the capacity of all Member States to promptly detect, speedily report and confirm outbreaks.

(c) To strengthen and sustain the capacity of all Member States to promptly respond to and recover from the negative effects of outbreaks and health emergencies.

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[11] World Health Organization (2015). Follow up of the WHA on the Ebola Virus Disease Outbreak and the Special Session of the Executive Board on Ebola: Roadmap for Action, September, 2015, accessed on 21 April 2016 at: http://www.who.int/about/who_reform/emergency-capacities/WHO-outbreasks-emergencies-Roadmap.pdf.

[12] World Health Organization (2012). WHO's response, and role as the health cluster lead in meeting the growing demands of health in humanitarian emergencies, 26 May 2012, WHA65.20, accessed on 17 April, 2016 at: http://www.wma.net/en/20activities/20humanrights/20distress/A65_R20-en.pdf

18. **Targets**

To strengthen and sustain the capacity of all Member States to prepare for and prevent health emergencies

(a) All Member States have legislation, laws, regulations, frameworks, policies and guidelines to support IHR and DRM implementation by 2018.

(b) All Member States have budget lines and allocated domestic resources to support IHR implementation by 2018.

(c) At least 80% of Member States have organized a joint external evaluation (JEE) of IHR core capacities by 2018 with WHO Regional coordination support.

(d) At least 80% of Member States will have conducted outbreak and disaster risk analysis and mapping in a multisectoral approach by 2018.

(e) At least 80% of Member States have all-hazards preparedness plans that are tested and resourced, by 2018.

(f) At least 80% of Member States will have the minimum IHR core capacities by 2020.

(g) A regional health workforce developed in collaboration with partners including the Africa CDC by 2017.

To strengthen and sustain the capacity of all Member States to promptly detect, speedily report and confirm outbreaks

(a) Over 90% of Member States are implementing IDSR including event-based surveillance systems with at least 90% country coverage by 2020.

(b) At least 80% of Member States have a functional national laboratory system and network as described in the joint external evaluation (JEE) tool by 2020.[13]

To strengthen and sustain the capacity of all Member States to promptly respond to and recover from the negative effects of outbreaks and health emergencies.

(a) At least 80% of Member States have a public health emergency operation centre (EOC) functioning according to minimum common standards by 2020.

(b) Over 90% of Member States have a multi-level and multi-faced risk communication strategy for real-time exchange of information by 2020.

(c) Over 80% of Member States will have an adequate health work force to respond to outbreaks and health emergencies as stipulated in the JEE tool by 2020.

19. **Guiding principles and values**

(a) **Country ownership and leadership,** with governments coordinating and ensuring that all interventions by partners are in line with relevant national guidelines.

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[13] World Health Organization. Joint External Evaluation tool (JEET), IHR (2005), accessed on 17th April 2016 at: http://apps.who.int/iris/bitstream/10665/204368/1/9789241510172_eng.pdf

(b) **Community participation,** with the involvement of communities, civil society and the private sector.

(c) **Gender and human rights** principles that ensure incorporation of gender equity and human rights perspectives into policies and programmes.

(d) **Equity** in access to services, focusing on highly vulnerable population groups, migrant populations, underserved areas and states emerging from conflict.

(e) **Strengthening partnerships** within and outside the health sector, with the private sector, non-state actors, research and academic institutions as well as regional economic communities. This is in line with the recently approved framework of engagement with non-State actors.[14]

(f) Fostering **intersectoral collaboration** at local and regional levels between human health, animal or veterinary health, the environment and wild life sectors using the "One health Approach".

(g) **Evidence-led and forward-looking** to take into account emerging trends, risks and health innovations.

(h) Intercountry, regional, subregional and cross-border cooperation to reinforce timely information sharing and coordinated interventions.

Priority interventions

To establish and sustain the capacity of all Member States to prepare for and prevent outbreaks and other health emergencies

20. **Formulate national legislation and policies** to prioritize disaster risk management, health security and IHR (2005) in the health sector strategic and development plans.

21. **Strengthen IHR coordination, implementation, communication and advocacy;** strengthen and sustain a multisectoral and multidisciplinary coordination and communication mechanism that is regularly tested and updated. Revise the terms of reference for the national IHR focal points to make them more responsive and accountable to all the relevant sectors. In addition, provide the focal points with the necessary logistics (office, transport and communication equipment) to make them more functional.

22. **Develop mechanisms for antimicrobial resistance (AMR) tracking and mitigation, including:** establishing surveillance systems for AMR, ensuring access to quality assured essential antibiotics[15], regulating and promoting the rational use of antibiotics in human medicine and in animal husbandry.

23. Develop and implement operational frameworks for z**oonotic diseases, emerging and re-emerging infectious diseases and environmental risk factors** using the "**One Health approach**".

24. **Develop operational frameworks for food safety and water quality monitoring, including:** designation of focal points for food safety in the relevant sectors, establishing operational links

[14] WHA69: *Sixty-ninth session of the WHA*. Geneva: WHO Framework of Engagement with Non-State Actors: http://www.who.int/mediacentre/news/releases/2016/wha69-28-may-2016/en/. last accessed on 21 June 2016.

[15] This includes ensuring the enforcement of regulatory mechanisms to prevent the use of fake and counterfeit products.

between public health surveillance and response staff and food as well as water safety, animal health and laboratories.

25. **Strengthen biosafety and biosecurity programmes,** including: safe and secure use, storage, disposal, and containment of pathogens and establish capacity for biological risk management.

26. In collaboration with the expanded programme on immunization (EPI) and other relevant stakeholders, **establish regional vaccine stockpiles; improve vaccine delivery and implementation** systems to facilitate preventive and reactive vaccination against epidemic-prone diseases.

27. **Implement resilience-building interventions in health facilities and at community levels:** new health facilities should be constructed to enable them to withstand the impact of hazards using the appropriate structural, non-structural and functional designs. Community members should participate in implementing some of the critical roles in the DRM interventions.

To strengthen and sustain the capacity of all Member States to promptly detect, speedily report and confirm outbreaks

28. **Strengthen the national laboratory systems and networks for** testing, confirmation and monitoring of priority diseases and pathogens. Strengthen capacity including appropriate training, provision of reagents, twinning laboratories for knowledge transfer and networks for sample referral.

29. **Strengthen IDSR (indicator, event-based and syndromic surveillance);** establish and sustain interoperable, interconnected, electronic data management and reporting systems, and improve capacity for analysis and dissemination of information and best practices.

30. Establish and sustain **the human resources to implement IHR core capacity** and DRM strategy requirements such as applied epidemiology training programmes in human and animal health; promoting South-South and North-South cooperation; formulate a public health workforce strategy that is reviewed annually; and contribute to the regional and global emergency health work-force including the establishment of the African volunteer health corps observatory.

To strengthen and sustain the capacity of all Member States to promptly respond to and recover from the negative effects of outbreaks and health emergencies.

31. **Increase investments in preparedness through**: joint external evaluations of the IHR core capacities, risk analysis and mapping using the district as the basic unit; develop and implement a multi-hazard national public health emergency preparedness and response plan; and map potential resources and earmark sufficient financial resources.

32. **Establish/strengthen emergency response operations** through the development of emergency operations centres (EOC) plans/procedures, incident management systems (IMS) and maintain multisectoral response and recovery capacity.

33. **Develop a national multi-hazard emergency risk communication plan** that is reviewed periodically; establish and test communication coordination with all partners and ensure continuous

wide-coverage communication, engagement and proactive media outreach guided by risk communication best practices.

Cross cutting interventions

34. **Strengthen research capacity for innovations**, sharing of public health data and scientific information and their use for evidence-led programming of health security interventions. Develop or strengthen mechanisms to link functional regional and subregional networks of research institutions with ministries of health. Accelerate efforts for local production of essential medicines and other areas of research during emergencies.

35. **Improve financial resource mobilisation for national health security** from domestic sources through the creation of a sustainable budget line or health security fund, including contributions to APHEF.

36. **Provide adequate support for cross cutting elements, such as:** establishing and sustaining resilient health systems; partnerships and networking with communities, engaging with civil society, nongovernmental organizations and enhancing public-private partnerships and providing adequate logistics and establishing robust logistics information systems.

Roles and responsibilities

MEMBER STATES

37. Member states should:

(a) Ensure multisectoral collaboration in the implementation of this strategy.

(b) Develop national plans and a clear road map with milestones to achieve and sustain the IHR core capacities, as well as the full implementation of the DRM strategy[16] including reviewing structures and systems to support implementation of this strategy.

(c) Commit domestic resources to implement the priority interventions. Sufficient resources will need to be allocated for implementation of national plans and for monitoring and evaluating progress.

(d) Conduct research to answer priority questions related to health security, risk mitigation and risk factor exposure.

(e) Honour contributions to APHEF to complement other emergency funds.

(f) Encourage participation of emergency funds experts in the functioning of the African volunteer health corps

[16] Resolution AFRI/RC62/R1 Disaster Risk Management: A Health Sector Strategy for the African Region http://www.afro.who.int/en/sixty-second-session.html, last accessed on 21 June 2016.

THE WHO SECRETARIAT AND PARTNERS

38. The WHO secretariat and Partners should:

(a) Disseminate the relevant information, products and technical guidelines to support implementation of this strategy.

(b) Support Member States to develop and implement strategic and annual plans that are regularly monitored and evaluated.

(c) Strengthen mechanisms for biosafety and biosecurity for dangerous pathogens and for addressing AMR.

(d) Establish a regional partnership forum for "One health" to serve as a platform for coordinated action, resource mobilizing and consensus-building among partners and Member States.

(e) Facilitate partnerships to improve preparedness, alert and response capacities and strengthen cross-country and cross-institutional collaboration.

(f) Strengthen national and regional networks of Research Institutes to support Member States to conduct research.

(g) Establish a regional health workforce including the African volunteer corps to promptly respond to health emergencies.

(h) Commit to support implementation of national action plans developed to bridge the gaps identified in IHR core capacities after JEE.

RESOURCE IMPLICATIONS

39. To achieve the targets set out in this strategy, investments (external and domestic) for health security need to increase substantially from the current average of US$ 0.02 to US$ 1-2 per capita per annum. The per capita estimates were derived from IDSR implementation costs in Member States in the African Region.[17,18] Refined estimates of the costing will be generated during implementation. Additionally, in line with the overall budget requirement for the new health emergencies programme approved by the WHA,[19] at least US$ 106.8 million will be needed by the WHO Secretariat (US$ 31.8 million for the regional offices and US$ 75 million for WHO country offices respectively) to provide support/backstopping to Member States annually. Moreover, a contingency fund for emergencies of up to US$ 50 million per annum will be needed.[20] Finally, investments for research and development have to increase.

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[17] Luswa-Lukwago J, et al. (2013). The implementation of Integrated Disease Surveillance and Response in Uganda: a review of progress and challenges between 2001 and 2007.

[18] Somda ZC, et al., (2009). Cost analysis of an integrated disease surveillance and response system: case of Burkina Faso, Eritrea, and Mali. Cost Eff Resour Allocation. 2009 Jan 8; 7:1.

[19] WHA *Sixty-ninth session* May 2016: The new Health Emergencies Programme http://www.who.int/mediacentre/news/releases/2016/wha69-25-may-2016/en/, last accessed on 21 June 2016

[20] The National Academy Press (2016). The Neglected Dimension of Global Security: A Framework to Counter Infectious Disease Crises (2016), accessed on 16 April 2016 at: http://www.nap.edu/catalog/21891/the-neglected-dimension-of-global-security-a-framework-to-counter

MONITORING AND EVALUATION

40. **Monitoring and evaluation of the strategy:** Progress made towards the attainment of the targets set out in this strategy will go to complement the achievements in DRM strategy implementation. The implementation of the strategy will be evaluated quarterly, annually, at midterm and end term. Data will be collected through IDSR, IHR joint external evaluations and assessments, review of DRM strategy targets, supervision and facility-based surveys to monitor progress and identify constraints. Mid-term reviews will be conducted in 2018 to assess interim progress; and a final review will be undertaken before development of the next strategy in 2020.

41. **Monitoring and evaluation of the surveillance systems:** A well-functioning IDSR allows for the monitoring of trends in priority public health events. Member States with support from WHO and partners are urged to monitor the performance of the IDSR system's key attributes, using the protocols detailed in the IDSR technical guidelines.[21]

CONCLUSION

42. The frequency and magnitude of disease epidemics and other health emergencies witnessed in the WHO African Region in the recent past are the greatest ever recorded. The Region may yet experience a worse scenario. Decisive action is needed now from Member States and their development partners to ensure that people in Africa and the world are better protected from outbreaks and other health emergencies.

43. Member States are urged to prioritize their programmes for health security and emergencies within the overall health sector budgets and national development plans. In responding to emergencies, every effort should be made to ensure that routine health services do not suffer. Emphasis should be put on establishing resilient health systems that can withstand the shock of disasters and potential damage from emergencies.

44. The Regional Committee is invited to review and adopt this strategy.

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[21] World Health Organization (2010). Technical Guidelines for Integrated Disease Surveillance and Response, Second Edition, accessed on 17 April 2016 at: http://www.afro.who.int/en/clusters-a-programmes/dpc/integrated-disease-surveillance/features/2775-technical-guidelines-for-integrated-disease-surveillance-and-response-in-the-african-region.html